Certification for Youth Camps 2017

Department of Health and Mental Hygiene

Environmental Health Bureau

Center for Healthy Homes and Community Services

6 Saint Paul St, Suite 1301

Baltimore, MD 21202-1608

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Queen Anne's ✦ Somerset ✦ Talbot
Wicomico ✦ Worcester

Mission Statement

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

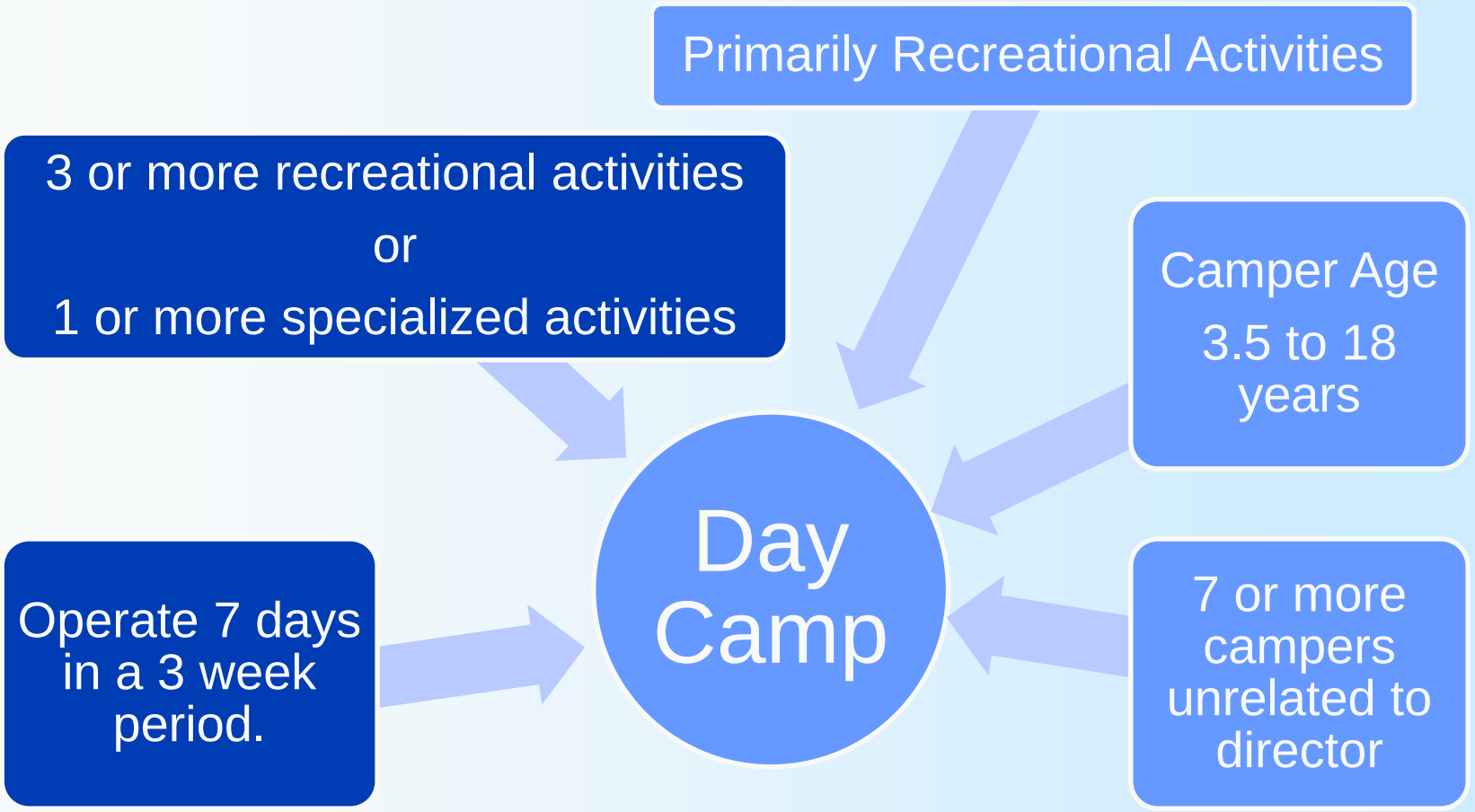
VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

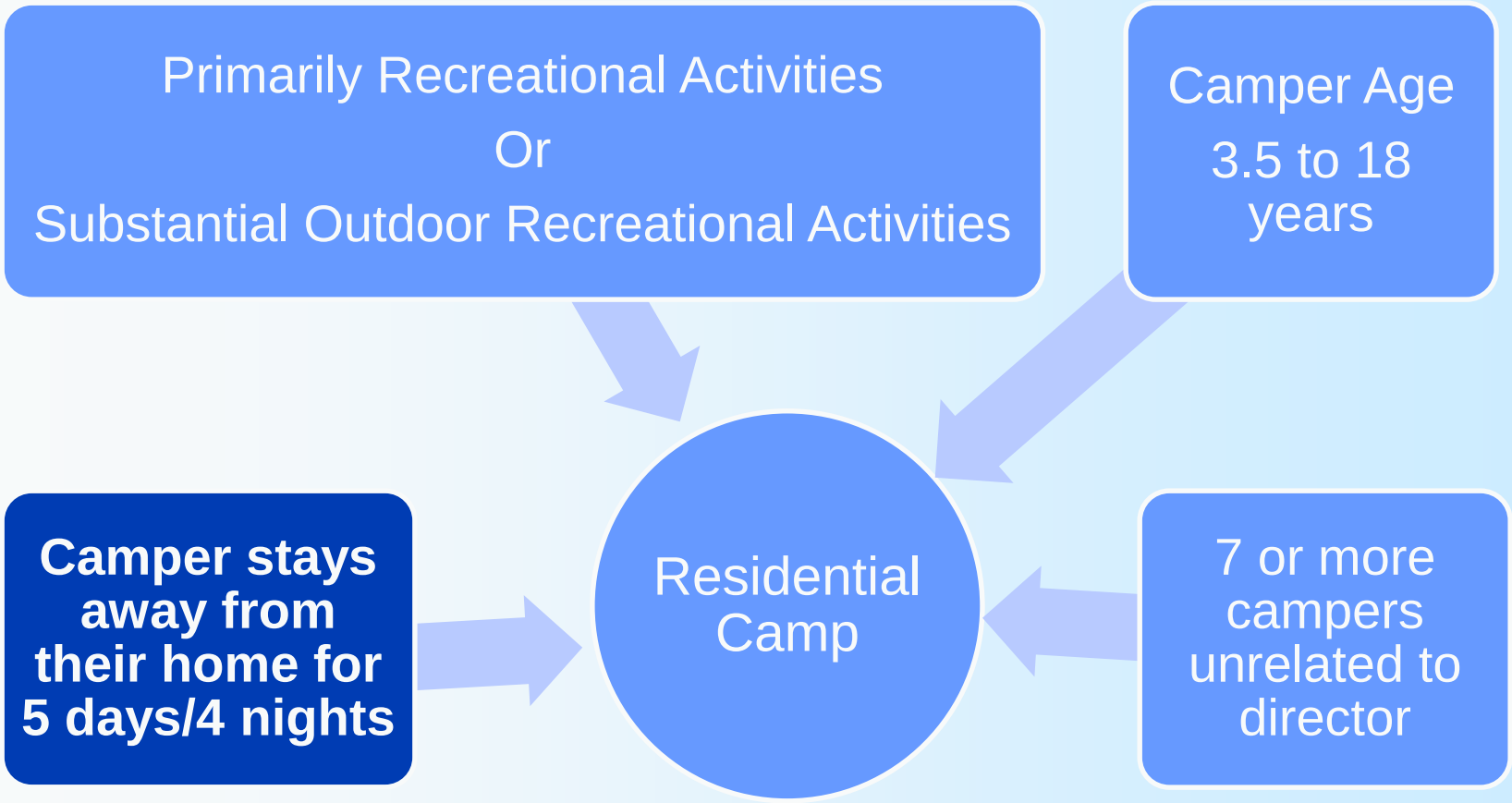
Legal Authority/Regulation

- Law: Youth Camp Act:
  Health General Title 14 Subtitle 4
- Regulation: COMAR 10.16.06
  - Updated in 2016
- Regulation: COMAR 10.16.07
  - Created in 2016
- Regulation: COMAR 10.01.17
  - Update in 2016

Is My Program a "Youth Camp"?



Is My Program a "Youth Camp"?



What Is **NOT** a Youth Camp?

- A licensed child care center
- A family day care home
- A program operating before or after a daily school session
- A competitive activity sponsored by a sports league
- An instructional program of 2 hrs. or less in a specialized activity

What Is **NOT** a Youth Camp?

- A summer school program taught by certified teacher and offering credit
- A program or activity where parents/guardians are present for duration, participate, and oversee activities of the child

What Is **NOT** a Youth Camp?

- A program enrolling children under the age of 3.5 years old cannot be licensed as a youth camp.
  - The operator should consult with Child Care Administration to see if a child care license is required.

New Application

- New Youth Camp Application
  - Print from Youth Camp website http://phpa.dhmh.maryland.gov/OEHFP/CHS/Shared%20Documents/ApplicationforNewYouthCamp.pdf
    Fill out completely, accurately, attach all required supporting documents, & fee

- Renewal Applications
  - Renewal packages are sent to operator
  - “Good Standing”- Pay reduced fee

- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

Fee Chart

Maryland Department of Health and Mental Hygiene
Center for Healthy Homes and Community Services
Youth Camp Application Fee Chart
Effective January 1, 2017

Day Camps		
Camper Days	**Regular Fee**	**"Good Standing" Fee**
1 to 500	$190	$45
501 to 2,000	$500	$125
2,001 to 5,000	$665	$165
5,001 or more	$855	$215

Residential, Day & Residential, Trip, or Travel Camps		
Camper Days	**Regular Fee**	**"Good Standing" Fee**
1 to 700	$500	$125
701 to 5,000	$1,000	$250
5,001 to 16,000	$1,500	$375
16,001 or more	$2,000	$500

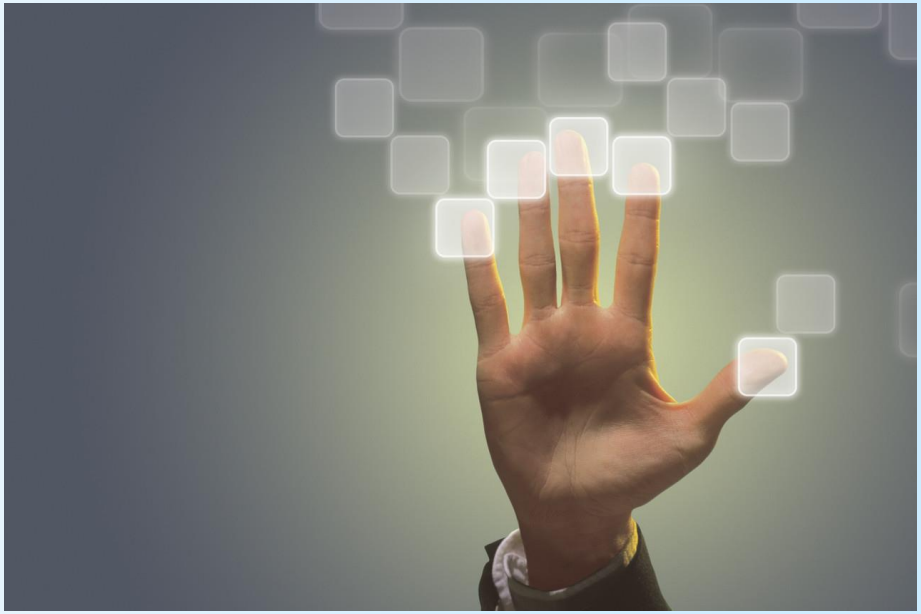
Renewal Application

- Renewal Applications
  - Renewal packages are sent to operator
  - “Good Standing”- Pay reduced fee
    - Application submitted on time
    - Annual Report submitted on time
    - All fees paid
    - No Critical Violations for 2 years
    - Self-Assessment submitted on time

- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

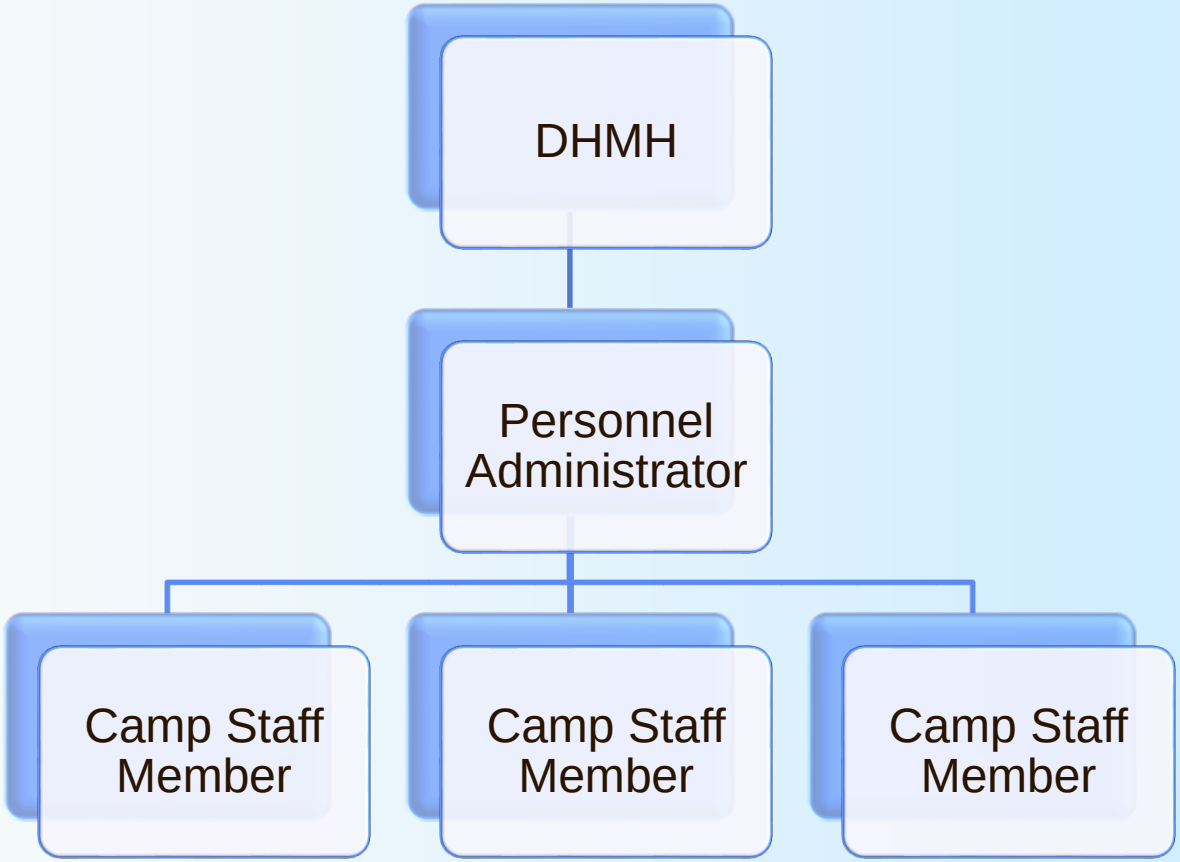
Criminal Background Checks

COMAR 10.16.06.21

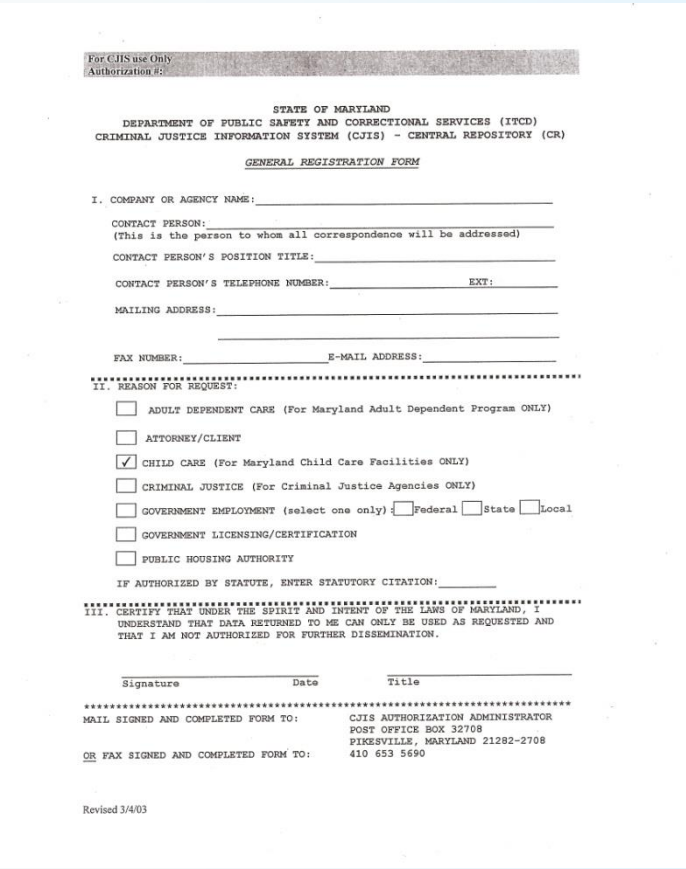


Criminal Background Checks

COMAR 10.16.06.21



Authorization Number



For CJIS use Only
Authorization #:

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES (ITCD)
CRIMINAL JUSTICE INFORMATION SYSTEM (CJIS) - CENTRAL REPOSITORY (CR)

GENERAL REGISTRATION FORM

I. COMPANY OR AGENCY NAME:_____

CONTACT PERSON:_____
(This is the person to whom all correspondence will be addressed)

CONTACT PERSON'S POSITION TITLE:_____

CONTACT PERSON'S TELEPHONE NUMBER:_____ EXT:_____

MAILING ADDRESS:_____

_____

FAX NUMBER:_____ E-MAIL ADDRESS:_____

II. REASON FOR REQUEST:

☐ ADULT DEPENDENT CARE (For Maryland Adult Dependent Program ONLY)

☐ ATTORNEY/CLIENT

☑ CHILD CARE (For Maryland Child Care Facilities ONLY)

☐ CRIMINAL JUSTICE (For Criminal Justice Agencies ONLY)

☐ GOVERNMENT EMPLOYMENT (select one only): ☐ Federal ☐ State ☐ Local

☐ GOVERNMENT LICENSING/CERTIFICATION

☐ PUBLIC HOUSING AUTHORITY

IF AUTHORIZED BY STATUTE, ENTER STATUTORY CITATION:_____

III. CERTIFY THAT UNDER THE SPIRIT AND INTENT OF THE LAWS OF MARYLAND, I UNDERSTAND THAT DATA RETURNED TO ME CAN ONLY BE USED AS REQUESTED AND THAT I AM NOT AUTHORIZED FOR FURTHER DISSEMINATION.

_____ _____ _____
Signature Date Title

MAIL SIGNED AND COMPLETED FORM TO: CJIS AUTHORIZATION ADMINISTRATOR
POST OFFICE BOX 32708
PIKESVILLE, MARYLAND 21282-2708

OR FAX SIGNED AND COMPLETED FORM TO: 410 653 5690

Revised 3/4/03

- Camp applies for Authorization Number through **CJIS**
- Results are sent to contact person
- Email notification
- View/print results from secure web site

Criminal Background Checks

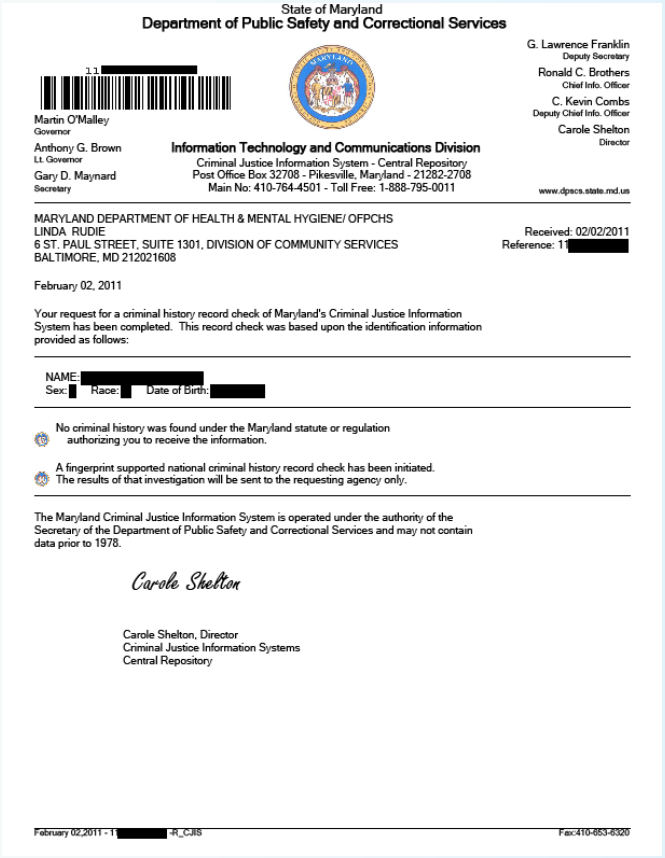
Maryland

And

FBI

- Must have completed MD & FBI check for all required employees
- Copy of results must be addressed to employer, not the employee

Criminal Background Checks



State of Maryland
Department of Public Safety and Correctional Services

G. Lawrence Franklin, Deputy Secretary
Ronald C. Brothers, Chief Info. Officer
C. Kevin Combs, Deputy Chief Info. Officer
Carole Shelton, Director

Martin O'Malley, Governor
Anthony G. Brown, Lt. Governor
Gary D. Maynard, Secretary

Information Technology and Communications Division
Criminal Justice Information System - Central Repository
Post Office Box 32708 - Pikesville, Maryland - 21282-2708
Main No: 410-764-4501 - Toll Free: 1-888-795-0011
www.dpscs.state.md.us

MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS
LINDA RUDIE
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES
BALTIMORE, MD 212021608

Received: 02/02/2011
Reference: 11[redacted]

February 02, 2011

Your request for a criminal history record check of Maryland's Criminal Justice Information System has been completed. This record check was based upon the identification information provided as follows:

NAME: [redacted]
Sex: [redacted] Race: [redacted] Date of Birth: [redacted]

No criminal history was found under the Maryland statute or regulation authorizing you to receive the information.

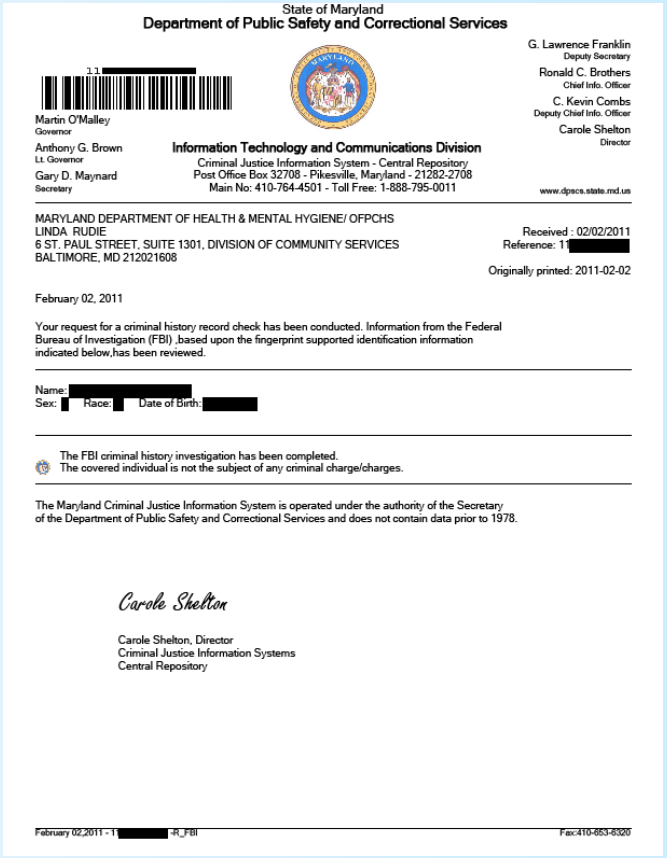
A fingerprint supported national criminal history record check has been initiated. The results of that investigation will be sent to the requesting agency only.

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and may not contain data prior to 1978.

Carole Shelton

Carole Shelton, Director
Criminal Justice Information Systems
Central Repository

February 02,2011 - 11[redacted]-R_CJIS Fax:410-653-8320



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LINDA RUDIE
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES
BALTIMORE, MD 212021608

Received : 02/02/2011
Reference: 11[redacted]

Originally printed: 2011-02-02

February 02, 2011

Your request for a criminal history record check has been conducted. Information from the Federal Bureau of Investigation (FBI) ,based upon the fingerprint supported identification information indicated below,has been reviewed.

Name: [redacted]
Sex: [redacted] Race: [redacted] Date of Birth: [redacted]

The FBI criminal history investigation has been completed.
The covered individual is not the subject of any criminal charge/charges.

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and does not contain data prior to 1978.

Carole Shelton

Carole Shelton, Director
Criminal Justice Information Systems
Central Repository

February 02,2011 - 11[redacted]-R_FBI Fax:410-653-8320

Fingerprints

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:

Date of birth: | SSN: | Gender: ☐ Male ☐ Female *(Please check)*

Height: ft. inches | Weight: lbs. | Eye Color: | Hair Color:

Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*

Place of Birth: | Citizenship:

Current address:

City: | State: | ZIP Code: -

Daytime Phone: | Evening Phone: | Driver's License #:

AGENCY INFORMATION

Agency Authorization #:

ORI # (if required): MD004455Y | Reason fingerprinted? CHILD CARE

Position Applied for:

Request Type: *(Choose one ONLY)*

- ☐ Adult Dependent Care
- ☐ Attorney/Client
- ☒ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

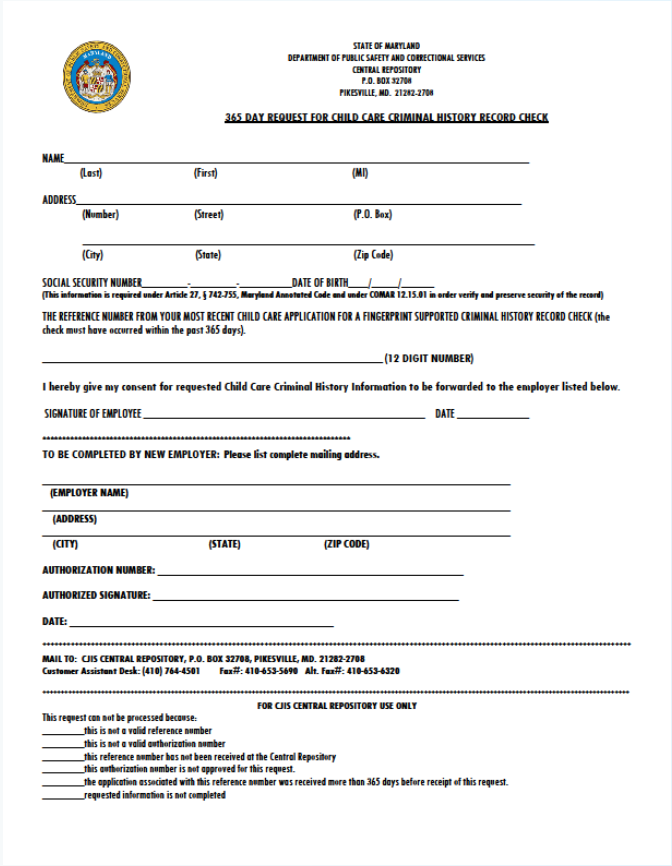
Nan
Add
City

Maryland CJIS no longer accepts inked fingerprints as of April 15, 2012, except for out of state.
Use LIVESCAN PRE-REGISTRATION APPLICATION

Personnel Administrator

- DHMH must have the personnel administrator's criminal background results from CJIS
- Use DHMH Authorization Number: 9400019171
- ***DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF MEMBERS***

365 Day Request



STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CENTRAL REPOSITORY
P.O. BOX 32708
PIKESVILLE, MD. 21282-2708

365 DAY REQUEST FOR CHILD CARE CRIMINAL HISTORY RECORD CHECK

NAME_____
(Last) (First) (MI)

ADDRESS_____
(Number) (Street) (P.O. Box)

_____
(City) (State) (Zip Code)

SOCIAL SECURITY NUMBER_____-_____-_____DATE OF BIRTH____/____/_____
(This information is required under Article 27, § 742-755, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

THE REFERENCE NUMBER FROM YOUR MOST RECENT CHILD CARE APPLICATION FOR A FINGERPRINT SUPPORTED CRIMINAL HISTORY RECORD CHECK (the check must have occurred within the past 365 days).

_____(12 DIGIT NUMBER)

I hereby give my consent for requested Child Care Criminal History Information to be forwarded to the employer listed below.

SIGNATURE OF EMPLOYEE _____ DATE _____

****

TO BE COMPLETED BY NEW EMPLOYER: Please list complete mailing address.

_____
(EMPLOYER NAME)
_____
(ADDRESS)
_____
(CITY) (STATE) (ZIP CODE)

AUTHORIZATION NUMBER: _____

AUTHORIZED SIGNATURE: _____

DATE: _____

****

MAIL TO: CJIS CENTRAL REPOSITORY, P.O. BOX 32708, PIKESVILLE, MD. 21282-2708
Customer Assistant Desk: (410) 764-4501 Fax#: 410-653-5690 Alt. Fax#: 410-653-6320

****

FOR CJIS CENTRAL REPOSITORY USE ONLY

This request can not be processed because:
_____this is not a valid reference number
_____this is not a valid authorization number
_____this reference number has not been received at the Central Repository
_____this authorization number is not approved for this request.
_____the application associated with this reference number was received more than 365 days before receipt of this request.
_____requested information is not completed

- Use for individuals who were fingerprinted for child care within last year
- Does not require fingerprints
- No charge

Background Clearance from Child Protective Services

- All employees must complete CPS Release of Information Form (DHR/SSA 1279).

- Personnel Administrator should use the sample form provided which includes the contact information for DHMH-CHHCS.

Reviewing Background Checks and Clearances

- Personnel Administrator must review MD and FBI background checks and CPS background clearance information.
- No hits for something in Regulation .21E.
- If hit for something in Regulation .21F must review accordingly.

Procedures

Emergency Procedures

- Regulation 10.16.06.34

Trip and Transportation

- Regulations 10.16.06.52, and .53

Supervision during routine activities

- Regulation 10.16.06.54

Specialized Activities

- Regulations 10.16.06.47, through .52

Child Abuse Prevention and Reporting

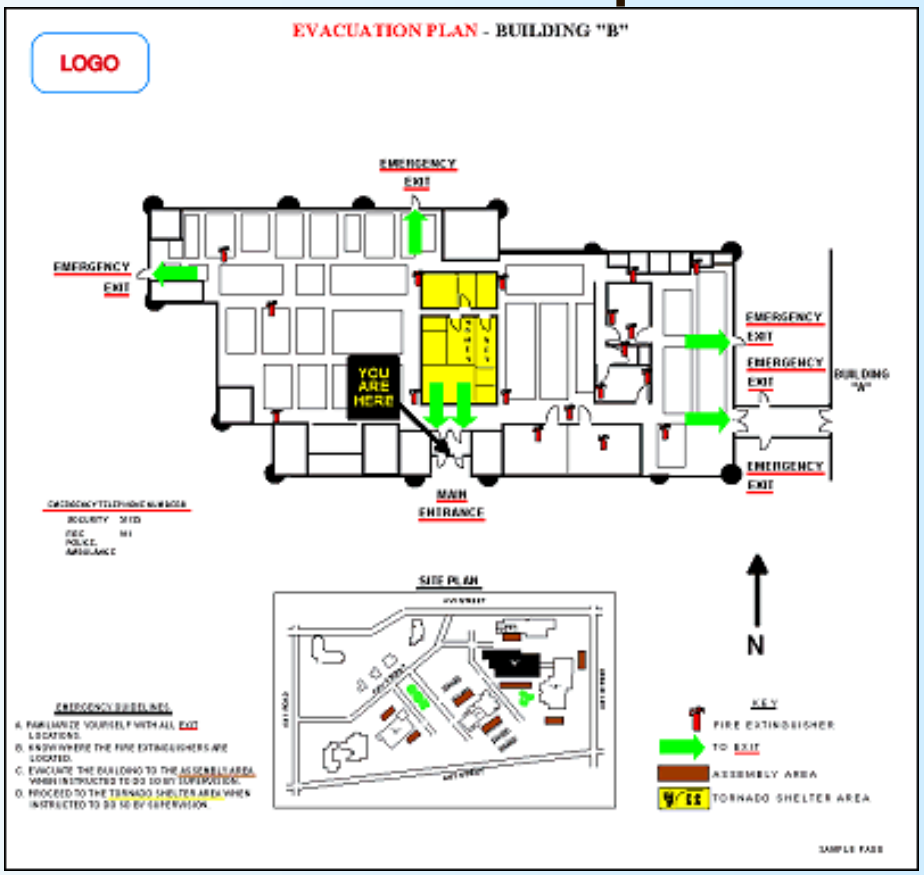
- Regulation 10.16.06.35

Emergency Procedures

- Regulation 10.16.06.34
  - Natural disasters and severe weather

Emergency Procedures

–Evacuation plan



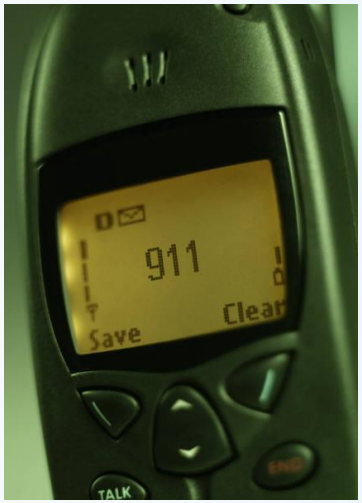
Emergency Procedures

–Missing campers

6 ?

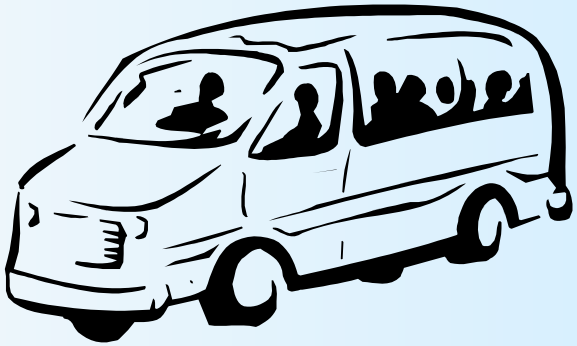
Emergency Procedures

–911



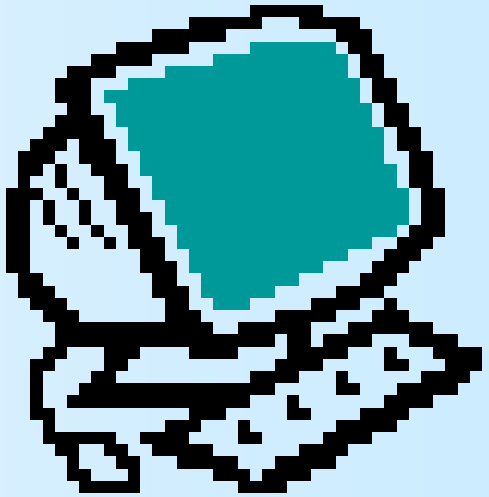
Emergency Procedures

–Transportation for Evacuation



Emergency Procedures

– Notify parents



Emergency Procedures

– Ensure camper safety

Trip and Transportation

- Regulations 10.16.06.52 and .53
- Written Safety Plans for:
  - Field trips (See Handout)
  - Transportation (See Handout)
    - Safety Seats for Younger Children
- Written parental authorization
- Rules
- Supervision

Specialized Activities Regulation .47 - .52

- All Specialized Activities
  - Director Present
  - Safety Plan Developed and Implemented
  - Staff Training
  - Staff Ratio (1 staff to 10 campers)
- Swimming
  - Swim ability test
  - Safety system to quickly account for campers
  - WATCHERS, WATCHERS, WATCHERS
- Marksmanship
- Horseback Riding

Specialized Activities Change to Regulation .51

A helmet is required for rock climbing or high ropes activities, except when an auto-belay system is utilized.

Supervision

Campers	Required Number of Adults and Assistant Counselors	
	Adults	Assistant Counselors or Adults
3 ½ to 5 years old		
1 to 8	1	0
9 to 16	1	1
17 to 24	1	2
6 to 10 years old		
1 to 15	1	0
16 to 30	1	2
	Or 2	0
11 years old or older		
1 to 15	1	0
16 to 30	1	2
	Or 2	0
31 to 40	2	2
	Or 3	0

Child Abuse Prevention and Reporting

Mandated Reporters

Child Abuse Prevention and Reporting

Regulation 10.16.06.35

- Develop and implement child abuse prevention and reporting plan ***see handout***
- Provide training to staff members on the prevention and reporting plan annually
- Keep sign-in sheet for training on file
- Keep a copy of the local DSS numbers on file

Facilities

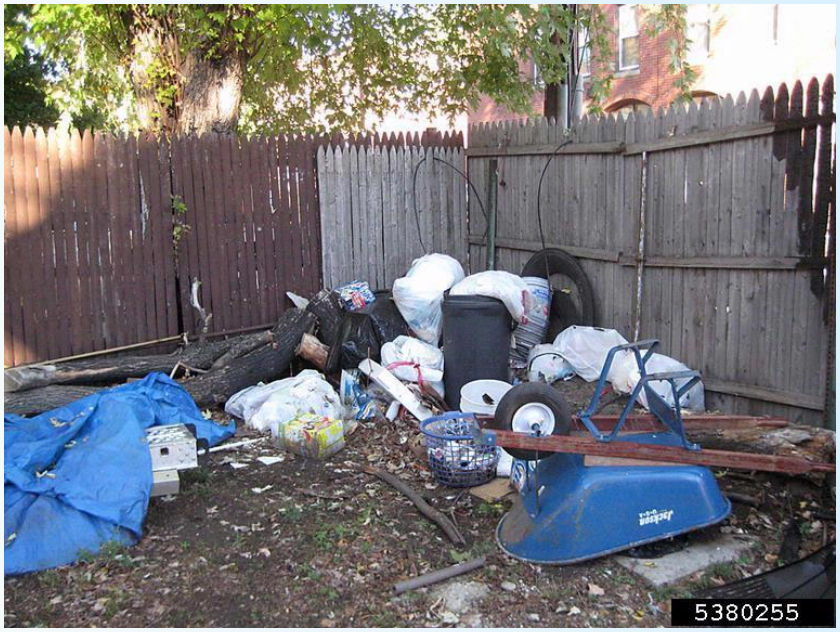
Type of Facility	Day	Residential
1 Toilet per	35 campers	15 campers
1 Hand Washing Unit per	35 campers	25 campers
1 Showerhead per	N/A	15 campers
1 Bed, Cot or Bunk per	N/A	1 camper

Facilities

- Garbage removal, COMAR 10.16.06.43
  - Durable containers in good repair
  - Collected as necessary to prevent overflow
  - Disposed of legally
  - Outside containers have:
    - Tight-fitting Lids
    - Are leak-proof, fly-proof, and rodent-proof

Facilities

- Insect and rodent control, COMAR 10.16.06.44
  - Minimize entry
  - Eliminate harborage



Documentation for Private Building

- Building
  - Use and Occupancy Permit

    Or
  - Master Plumber and Master Electrician Letters
- Water and Sewage
  - Public Water and Sewer

    Or
  - Local Health Approval Form
- Fire Marshal Inspection
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD

Documentation for School/Government Building

- Building Safety Form
  - Covers:
    - Water
    - Sewage Disposal
    - Plumbing
    - Electrical
    - Fire
    - Building/Zoning
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD

Health Program

Health Supervisor

COMAR 10.16.07.04

- Doctor
- Nurse
- Certified Nurse Practitioner
- **Duties**
  - Review & Approve Health Program Annually
  - Oversee or Delegate Medication Administration
  - Oversee Health Treatment Area
  - Review Camper Health Forms

Health Program

CPR/First Aid

COMAR 10.16.07.04

- Minimum of 2 Adults
  - Certification Issued by National Organization
- On Duty at All Times
  - From 1st camper arrival to last camper pick up
- Field Trips
  - One with trip and one at camp if campers stay behind

Health Program

Written Health Program

COMAR 10.16.07.03

Health Program

Medications

COMAR 10.16.07.14

- Covers Prescription and Nonprescription Medications
- Delegation ability varies depending on credentials of Health Supervisor
- Self-administration vs. Staff Administration
- Prescriptive Order for All Medication – DHMH form
  (may be used at multiple camps for one season)
- Parental Consent Documented
- Standing Orders
- Sunscreen, see January 25, 2017 memo

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- Applicant = Someone that:

1) Operates a youth camp

2) Is at least 18 years old

3) Has successfully completed an emergency epinephrine training program approved by the department.

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

•The applicant may apply to the Department for a Certificate for Emergency Epinephrine by submitting a written policy that includes:

1) Designation of agents
2) The name of the approved emergency epinephrine educational training program
3) Procedures to:
    a) Store the epi pen
    b) Notify parents it is available
    c) Maintain epi pen in secure manner
    d) Report use of epi pen according to .06
    e) Train certificate holder and agent annually
    f) Keep training docs. for 3 years

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

•An emergency epinephrine educational training program shall include:

1) The signs and symptoms of anaphylaxis

2) Use of an emergency auto-injectable epinephrine pen

3) Follow-up procedures with a parent or guardian after an emergency auto-injectable epinephrine is administered

4) A skills demonstration

5) A written examination

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

•An individual teaching an emergency epinephrine educational training program shall be licensed as a physician, a register nurse, or a certified nurse practitioner.

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- A certificate for emergency epinephrine holder may:

1) On presentment of a certificate for emergency epinephrine, receive from any physician licensed to practice medicine in the State a prescription for auto-injectable epinephrine; and

2) Possess and store prescribed auto-injectable epinephrine

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- In an emergency, a certificate for emergency epinephrine holder or agent may administer auto-injectable epinephrine to an individual who is experiencing or believed in good faith by the certificate holder or agent to be experiencing anaphylaxis.

Health Program

Treatment Area

COMAR 10.16.07.13

Day Camp

Health Program

Treatment Area

COMAR 10.16.07.13

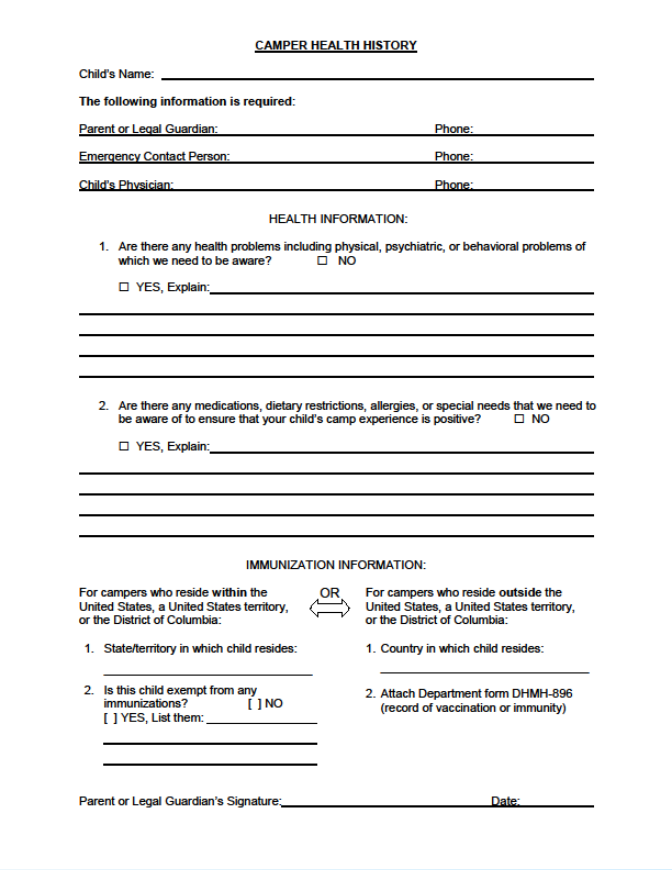
Residential Camp

- Hot/Cold Running Water
- Bathroom with Flush Toilets
- Hand Sink, Shower, and Isolation & Convalescent Area
- External Lighting

Health Program

Health Records

COMAR 10.16.07.08



CAMPER HEALTH HISTORY

Child's Name: _____

The following information is required:

Parent or Legal Guardian: _____ Phone: _____

Emergency Contact Person: _____ Phone: _____

Child's Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ NO

   ☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For campers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides: _____
2. Is this child exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

OR

For campers who reside **outside** the United States, a United States territory, or the District of Columbia:

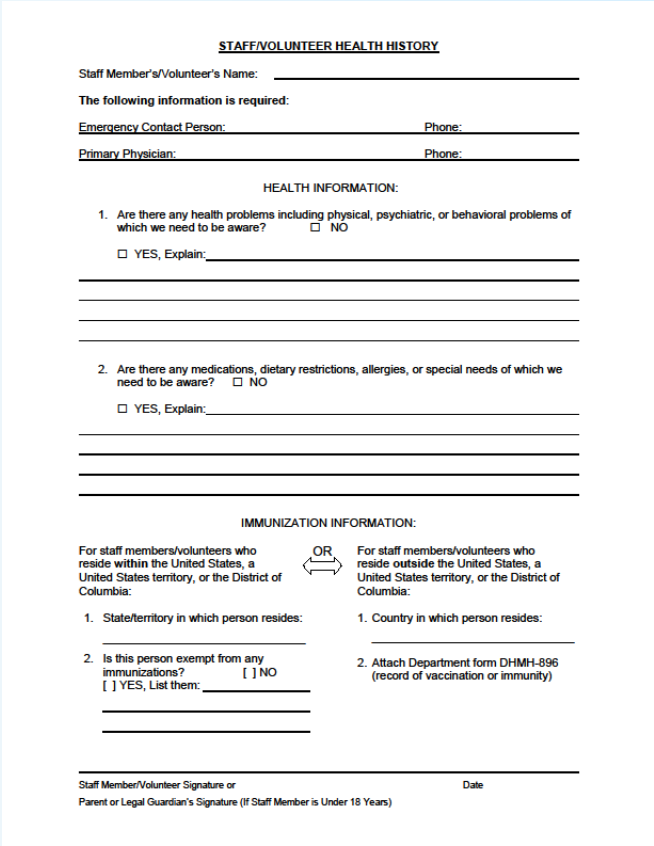
1. Country in which child resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

Parent or Legal Guardian's Signature: _____ Date: _____

Health Program

Health Records

COMAR 10.16.07.09



STAFF/VOLUNTEER HEALTH HISTORY

Staff Member's/Volunteer's Name: _____

The following information is required:

Emergency Contact Person: _____ Phone: _____

Primary Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For staff members/volunteers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which person resides: _____
2. Is this person exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

OR

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which person resides: _____
2. Attach Department form DHMH-896 (record of vaccination or immunity)

Staff Member/Volunteer Signature or Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years) _____ Date

Health Program

Health Log

COMAR 10.16.07.05

See Sample Health Log

Must Include:

1. Date
2. Name of Camper
3. Ailment
4. Treatment Prescribed
5. Name or Initials of Person Administering Care

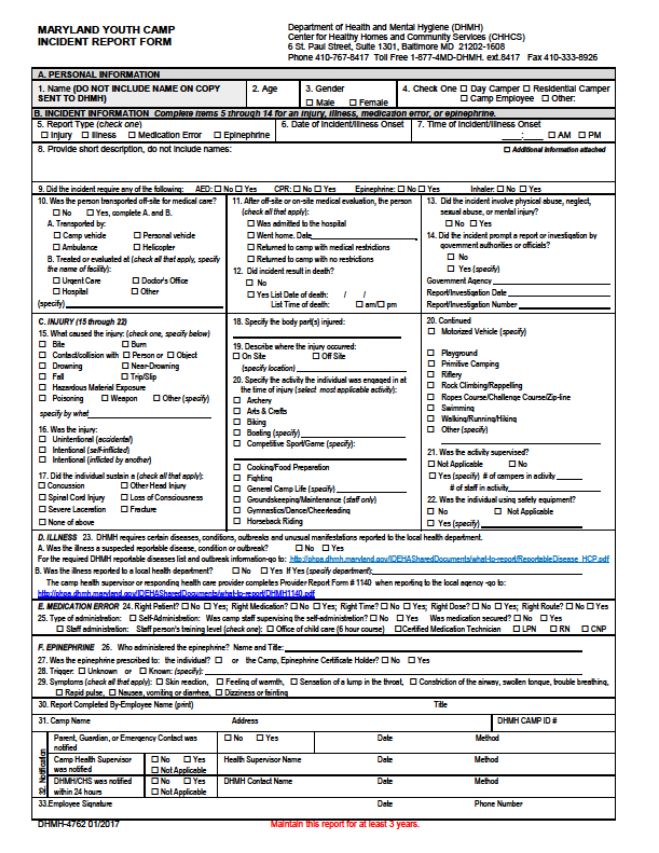
Must Be:

1. On Lined Paper
2. Kept Confidential
3. In Locked Compartment
4. Available to Department
5. Retained for 3 years
6. Recorded in Ink
7. No Skipped Lines
8. Spiral Book Must Have Sequentially Numbered Pages

Health Program

Incident Report

COMAR 10.16.07.06 and .07



MARYLAND YOUTH CAMP
INCIDENT REPORT FORM

Department of Health and Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608
Phone 410-767-8417 Toll Free 1-877-4MD-DHMH. ext.8417 Fax 410-333-8926

A. PERSONAL INFORMATION

1. Name (DO NOT INCLUDE NAME ON COPY SENT TO DHMH)	2. Age	3. Gender ☐ Male ☐ Female	4. Check One ☐ Day Camper ☐ Residential Camper ☐ Camp Employee ☐ Other:

B. INCIDENT INFORMATION *Complete items 5 through 14 for an injury, illness, medication error, or epinephrine.*

5. Report Type (check one) ☐ Injury ☐ Illness ☐ Medication Error ☐ Epinephrine	6. Date of Incident/Illness Onset	7. Time of Incident/Illness Onset ☐ AM ☐ PM

8. Provide short description, do not include names: ☐ Additional information attached

9. Did the incident require any of the following: AED: ☐ No ☐ Yes CPR: ☐ No ☐ Yes Epinephrine: ☐ No ☐ Yes Inhaler: ☐ No ☐ Yes

10. Was the person transported off-site for medical care? ☐ No ☐ Yes, complete A. and B.
A. Transported by: ☐ Camp vehicle ☐ Personal vehicle ☐ Ambulance ☐ Helicopter
B. Treated or evaluated at (check all that apply, specify the name of facility): ☐ Urgent Care ☐ Doctor's Office ☐ Hospital ☐ Other (specify)

11. After off-site or on-site medical evaluation, the person (check all that apply): ☐ Was admitted to the hospital ☐ Went home. Date ☐ Returned to camp with medical restrictions ☐ Returned to camp with no restrictions

12. Did incident result in death? ☐ No ☐ Yes List Date of death: / / List Time of death: ☐ am/☐ pm

13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury? ☐ No ☐ Yes

14. Did the incident prompt a report or investigation by government authorities or officials? ☐ No ☐ Yes (specify) Government Agency Report/Investigation Date Report/Investigation Number

C. INJURY (15 through 22)

15. What caused the injury: (check one, specify below) ☐ Bite ☐ Burn ☐ Contact/collision with ☐ Person or ☐ Object ☐ Drowning ☐ Near-Drowning ☐ Fall ☐ Trip/Slip ☐ Hazardous Material Exposure ☐ Poisoning ☐ Weapon ☐ Other (specify) specify by what

16. Was the injury: ☐ Unintentional (accidental) ☐ Intentional (self-inflicted) ☐ Intentional (inflicted by another)

17. Did the individual sustain a (check all that apply): ☐ Concussion ☐ Other Head Injury ☐ Spinal Cord Injury ☐ Loss of Consciousness ☐ Severe Laceration ☐ Fracture ☐ None of above

18. Specify the body part(s) injured:

19. Describe where the injury occurred: ☐ On Site ☐ Off Site (specify location)

20. Specify the activity the individual was engaged in at the time of injury (select most applicable activity): ☐ Archery ☐ Arts & Crafts ☐ Biking ☐ Boating (specify) ☐ Competitive Sport/Game (specify): ☐ Cooking/Food Preparation ☐ Fighting ☐ General Camp Life (specify) ☐ Groundskeeping/Maintenance (staff only) ☐ Gymnastics/Dance/Cheerleading ☐ Horseback Riding

20. Continued ☐ Motorized Vehicle (specify) ☐ Playground ☐ Primitive Camping ☐ Rifling ☐ Rock Climbing/Rappelling ☐ Ropes Course/Challenge Course/Zip-line ☐ Swimming ☐ Walking/Running/Hiking ☐ Other (specify)

21. Was the activity supervised? ☐ Not Applicable ☐ No ☐ Yes (specify) # of campers in activity # of staff in activity

22. Was the individual using safety equipment? ☐ No ☐ Not Applicable ☐ Yes (specify)

D. ILLNESS 23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department.
A. Was the illness a suspected reportable disease, condition or outbreak? ☐ No ☐ Yes
For the required DHMH reportable diseases list and outbreak information go to: http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/ReportableDisease_HCP.pdf
B. Was the illness reported to a local health department? ☐ No ☐ Yes If Yes (specify department)
The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency -go to:
http://phpa.dhmh.maryland.gov/IDEHASharedDocuments/what-to-report/DHMH1140.pdf

E. MEDICATION ERROR 24. Right Patient? ☐ No ☐ Yes; Right Medication? ☐ No ☐ Yes; Right Time? ☐ No ☐ Yes; Right Dose? ☐ No ☐ Yes; Right Route? ☐ No ☐ Yes
25. Type of administration: ☐ Self-Administration: Was camp staff supervising the self-administration? ☐ No ☐ Yes Was medication secured? ☐ No ☐ Yes
☐ Staff administration: Staff person's training level (check one): ☐ Office of child care (6 hour course) ☐Certified Medication Technician ☐ LPN ☐ RN ☐ CNP

F. EPINEPHRINE 26. Who administered the epinephrine? Name and Title:
27. Was the epinephrine prescribed to: the individual? ☐ or the Camp, Epinephrine Certificate Holder? ☐ No ☐ Yes
28. Trigger: ☐ Unknown or ☐ Known: (specify):
29. Symptoms (check all that apply): ☐ Skin reaction, ☐ Feeling of warmth, ☐ Sensation of a lump in the throat, ☐ Constriction of the airway, swollen tongue, trouble breathing, ☐ Rapid pulse, ☐ Nausea, vomiting or diarrhea, ☐ Dizziness or fainting

30. Report Completed By-Employee Name (print) Title

31. Camp Name Address DHMH CAMP ID #

Notification					
	Parent, Guardian, or Emergency Contact was notified	☐ No ☐ Yes		Date	Method
	Camp Health Supervisor was notified	☐ No ☐ Yes ☐ Not Applicable	Health Supervisor Name	Date	Method
	DHMH/CHS was notified within 24 hours	☐ No ☐ Yes ☐ Not Applicable	DHMH Contact Name	Date	Method

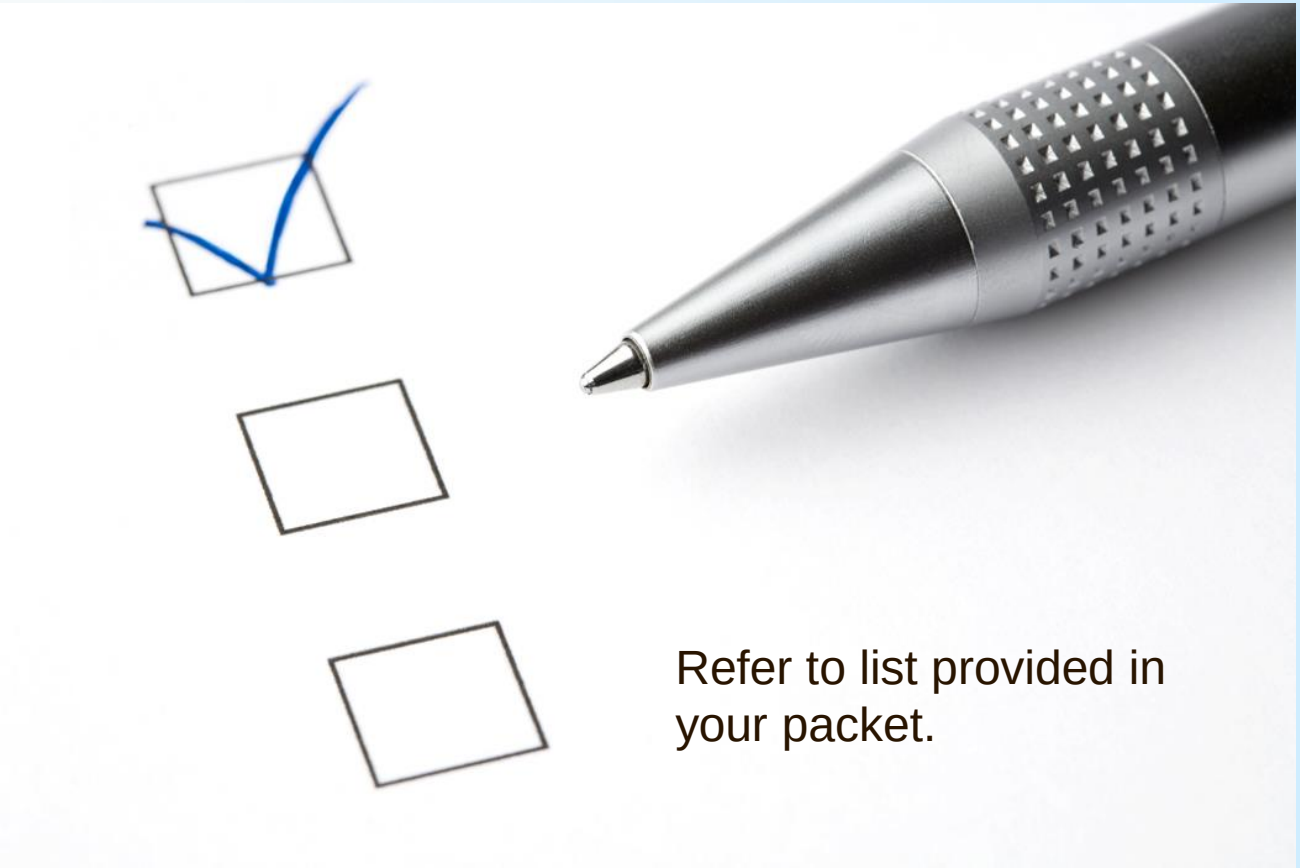
33.Employee Signature Date Phone Number

DHMH-4762 01/2017 Maintain this report for at least 3 years.

Health Program

Acute Illness & Communicable Disease

COMAR 10.16.07.12



Staff Training and Certification

- Training
  - Document staff training for the following:
    - Health Program
      - Including Medication Administration
    - Emergency Plan
    - Trip Safety Plan
    - Transportation Safety Plan
    - Specialized Activities Safety Plans
    - Child Abuse Prevention and Reporting

- CPR and First Aid certification
  - Document current CPR/first aid
  - Ensure that at least 2 adults with CPR/FA are on duty during camp

Submitting Required Reports

- COMAR 10.16.06.06 and COMAR 10.16.07.06

- Annual Report must be sent to Center for Healthy Homes and Community Services within 4 weeks of camp ending along with any required injury/illness reports.

Submitting Required Reports

- Camps will be able to submit Annual Report online.

https://envhlthlicensing.dhmh.maryland.gov/Account/Login

- DHMH is working on finalizing the Incident Report for online submission as well.

Questions